DOCUMENT RESUME

ED 306 317 UD 026 578

AUTHOR Bliatout, Bruce Thowpaou
TITLE Hmong Refugees: Some Barriers to Some Western Health Care Services.
PUB DATE 5 Mar 88
NOTE 13p.; Paper presented at the Southeast Asians in the United States Conference (March 5, 1988, Tempe, AZ).
PUB TYPE Reports - Descriptive (141) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Asian Americans; Attitudes; Cross Cultural Studies; *Cultural Background; *Cultural Differences; Family Role; Health Education; Health Personnel; Health Programs; *Health Services; Limited English Speaking; Program Development; Program Improvement; Refugees; Sex Role
IDENTIFIERS *Access to Health Care; Health Attitudes; *Hmong People; United States

ABSTRACT

There are an estimated 80,000 Hmong refugees now living in the United States. This paper identifies some of the barriers that have delayed or hindered Hmong access to health services in the United States. The following barriers are discussed: (1) physical barriers, including language and interpreter barriers; (2) cultural values, including beliefs about causes of illness, fear of invasive treatment, male/female cultural roles, and clan/family roles; and (3) differences in expectations of health care, including examination, diagnosis, and medication. Through cross-cultural training for Western health personnel, and through health education for the refugees, these barriers can be eliminated. Other recommendations for improving Hmong access to Western health care are offered. A brief bibliography is included. (BJV)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED306317

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Bruce T. Bliatout
Multnomah County Health Division

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

HMONG REFUGEES: SOME BARRIERS TO SOME WESTERN HEALTH CARE SERVICES

By

Bruce Thowpaou Bliatout
Health Program Development Specialist
Multnomah County Health Division
426 SW Stark, 2nd Floor
Portland, OR 97204

Presented At

Southeast Asians in the United States Conference

Program for Southeast Asian Studies
Arizona State University
Tempe, AZ 85287-3706

March 5, 1988

UD 026 578

TABLE OF CONTENTS

	Page #
Introduction	1
Physical Barriers	2
Language Barrier	2
Interpreter Barrier	3
Other Physical Barriers	3
Different Cultural Values	4
Beliefs on Causes of Illness	4
Fear of Invasive Treatment	5
Male/Female Cultural Roles	5
Clannal/Family Roles	5
Rumor of Casualties	6
Negative Past Experiences	6
Difference in Expectations of Health Care	7
In the Patient Room	7
Examination	7
Diagnosis	7
Medication	8
Recommendations	8
Conclusion	9
References	10

HMONG REFUGEES: SOME BARRIERS TO SOME WESTERN HEALTH CARE SERVICES

By

Bruce Thowpaou Bliatout
Multnomah County Health Division
Portland, Oregon
February 7, 1988

INTRODUCTION

The Hmong ethnic group is a group that exist throughout Southern China, Vietnam, Laos, Thailand, and Burma. The majority lived semi-autonomously, away from the cities on the rural mountainsides of Asia. Thus, they have preserved their language and culture for generations.

The Hmong of Laos became involved in the cold wars of the country during the early 1960s through 1975. Being familiar with the mountainous terrain, they made excellent guerilla soldiers and many Hmong were employed by the American supported military forces. When the government of Laos changed hands in 1975, thousands of Hmong had no alternative but to become refugees rather than face persecution and death in Laos.

There are an estimated 90,000 Hmong refugees now living in the United States. The largest Hmong communities can be found in cities of the California Central Valley such as Fresno, Stockton, and Merced. Another large Hmong community is found in the twin cities of St. Paul and Minneapolis. Numerous other smaller Hmong communities are found scattered across the continental U.S.A.

In cities where the Hmong presence has become noticeable, some noted Hmong resistance and/or barriers which have delayed or hindered Hmong access to Western health services. This paper presents an itemization of some of these

barriers in the hope that by understanding them, the barriers can be taken down. There are several different types of barriers which Hmong and other Indochinese refugee groups encounter when dealing with Western health services. These include simple physical barriers, different cultural values, and different expectations of medical care which deter acceptance of some common Western medical procedures.

PHYSICAL BARRIERS

Physical barriers, on the surface, appear to be the most common problems encountered and thus the easiest to identify. Sometimes they are thought to be the easiest to remedy. While this can be true to a certain extent, sometimes they are also the most difficult to overcome. Or sometimes they are the hardest for Western Health Practitioners to accept and to deal with.

Language Barriers. Perhaps the most obvious barrier for Hmong refugees to access Western medical services is the continuing language barrier. At this point in time, some twelve years after the Hmong began resettling in the United States, most Hmong children and teens have a very good command of, at least, conversational English. Many young adults also speak fairly good English, or are at least able to communicate with health practitioners. However, many Hmong individuals who are 35 years old or older still have difficulty with the English language. Individuals of this age or older were born and raised in Laos where the majority did not have the opportunity to attend formal schooling. Thus, even if English as a Second Language classes are available, the learning process can be slow.

This barrier makes it difficult to telephone to make an appointment, difficult to verbalize the symptoms of an illness, and often impossible to understand the explanation of a therapy or instructions for medication.

Interpreter Barriers. One of the answers to language barriers, is of course to use an interpreter. This, in itself, can also present other kinds of barriers. For instance, a Hmong woman may not feel comfortable telling a male interpreter of her gynecological problems; or a Hmong man may not want a daughter to interpret for him. Also, when utilizing an interpreter, a health practitioner cannot be really sure what communication is truly going across. The practitioner must be careful to use only words the interpreter can understand. In some cases, the practitioner may receive inappropriate responses and not know if the interpreter is not interpreting correctly or if the patient is not responding correctly. Sometimes the interpreter may selectively interpret only what she/he thinks is relevant.

Other Physical Barriers. Other physical barriers include financial, transportation, and knowledge of the location of the medical facilities. A recent case brought to my attention by a nurse practitioner in a medical clinic involved an Indochinese woman who called up and said she thought she had malaria. An immediate appointment was set up for her after the evaluation and she was instructed to report to a nearby hospital as the laboratory facilities there were better equipped. Although an appointment was made for her there, she did not show up. The next day she appeared at the clinic with no appointment. The nurse practitioner saw her and insisted she go to the hospital for testing. The client refused and claimed "not to want to bother anyone." This case illustrates how it cannot be assumed that refugees, particularly older ones or newly arrived ones, are able to overcome these seemingly simple barriers to access health care.

DIFFERENT CULTURAL VALUES

Living isolated on the higher elevations of the mountains of Asia, the Hmong developed their own unique culture. While their culture shares some common traits with other Asian cultures, it is nevertheless separate and different. Hmong refugees also are different in other ways than many other refugees. Most come from rural backgrounds with little or no formal education. Many other refugees had at least a minimum of education and exposure to limited Western facilities through living in towns and cities. Certain aspects of the traditional Hmong culture and former lifestyles can slow down the process of integrating Hmong refugees into a health delivery system.

Belief on Causes of Illness. Traditional Hmong persons believe that illness arises from two major causes. One is natural causes, including exposure to the elements, trauma/accidents, ingesting something wrong, and the change in weather and old age. The other is spiritual causes. The Hmong traditional religion is a mixture of Ancestor Worship and Animism. It is commonly believed that Ancestor spirits, nature spirits, and evil spirits cohabit the world, and if offended, can cause illness and death. Illness such as colds, flu, and various body aches are usually thought to be caused by natural causes. Serious illnesses, as well as chronic illnesses, may be attributed to spiritual causes. There is some gray area such as various types of miscellaneous pains in which it is not certain whether the cause of illness is natural or spiritual.

For the Hmong who retain their traditional religion, some may resist seeking Western medical help for what is considered a spiritually related problem. Certain set rituals and ceremonies may be considered the most appropriate therapy.

Fear of Invasive Treatment. Hmong who retain their traditional religion also believe in reincarnation. Many have a strong belief that what happens to the physical body in the present life will affect their reincarnation. Any surgery is considered the removal of part of the body. This removal may mean that in a future life the person may be born with a missing limb or some other deformity. Sometimes, any mention of even the possibility of surgery will scare a client into never returning to a health clinic.

Continued insistence of taking large blood samples may also inhibit some Hmong clients from returning to a physician. While small amounts of blood are considered acceptable for testing, more than a small test tube is considered weakening to the body.

Male/Female Cultural Roles. In the Hmong society there are both male and female traditional healers. The Hmong Shaman is the most commonly sought healer. She/he performs various spirit rituals and ceremonies without having to physically examine or palpate the patient. Thus, it is acceptable for a male Shaman to treat a female client, and vice versa. This is also true for Hmong herbalists. For any other Hmong healing art which necessitates touching, e.g., massage, acupuncture, scraping, etc., unless very close relatives, in general, males treat other males, and females treat other females.

Some Hmong women who have a gynecological exam done by a male physician may be inhibited from returning to a clinic. This may account in part for some Hmong women not seeking prenatal care, even when available at no cost.

Clannal/Family Roles. In Hmong society the clan and family is perhaps considered the most important definition of a person. What this means is that what the clan or family thinks is the best course of action for an individual, is probably what that individual will do. Thus, sometimes even when a physician or a nurse spends a lot of time with a patient, calls in an interpreter, and

seems to convince a patient to agree to a certain course of treatment, this can mean nothing if his family and clan do not approve. So it is advisable for direct services providers to include family members and/or clan leader(s) during case treatment consultation.

Rumor of Casualties. Many Hmong communities in the United States have retained a close system of communications and support. Information as well as rumors is spread throughout this communication system very rapidly. While this is often a type of support system, when rumors are spread it can also have negative effects.

Occasionally there are cases when a Hmong person dies in a hospital. Many Hmong family members cannot understand what caused the death. Sometimes they may bring a person into a hospital for what they perceive to be a minor problem and a much more serious underlying problem is discovered. When a death occurs in such a case it can cause the Hmong community to believe that either the Western practitioners were grossly negligent or that they purposely wanted to harm them. At the present time there may be some rumors that because they are refugees, hospitals may use them experimentally and this can cause higher death rates for refugees. Rumors of this kind give rise to mass fears and consequently the majority of a community may no longer be willing to seek Western medical health care.

Negative Past Experience. Due to many cultural differences, some Hmong have had negative experiences with Western health facilities and personnel. For example, a Hmong woman may perceive that she was forced to have her child by Caesarean Section. After such a procedure she and her peers often consider that she is disabled and no longer able to function at full capacity. She may, therefore, refuse to ever return to a Western health care facility and may actively dissuade friends and relatives from doing so also. A story told about

an experience such as this may grow into a rumor and spread throughout a community and eventually nationwide. With each telling of the story, the story grows worse and more and more people have fears about Western medicine.

DIFFERENCE IN EXPECTATIONS OF HEALTH CARE

The cultural background that many Hmong refugees come from can lead to differences in expectations in what good medical treatments should be. These expectations mainly center around what they expect a physician to be able to do, but also in how they are treated in general.

In the Patient Room. Most Hmong persons are uncomfortable if asked to strip and put on a patient gown before even seeing a doctor. In general, it is better to treat them with their clothes on, particularly if the medical practitioner is the opposite sex of the patient.

Examination. A "good" exam is perceived as being one in which the doctor spends some time actually talking and physically examining the patient. Use of the stethoscope is perceived as very good. Examination of the eyes, nose, ears, and mouth is also considered good. Palpation of any sore area is also considered appropriate. Requesting a urine sample and even a small blood sample is also considered part of a good examination.

Diagnosis. To the Hmong individual, a definitive diagnosis at the completion of an exam is considered the greatest test of whether the doctor is competent or incompetent. A Hmong person who is told that "nothing is wrong" or that "the cause of the illness is unknown" concludes that the doctor is "not good." This emphasis on the need for an immediate diagnosis may stem from the traditional use of the Hmong Shaman, who, once she/he performs a certain ritual, is able to state immediately which spirit or what reason is causing the illness, what needs to be done, and when recovery may be expected.

Medication. The Hmong are quite used to taking herbal medicine for a variety of sickness. Taking pills is considered quite appropriate, provided it is for a reasonably short length of time. The Hmong believe that once a diagnosis is made, the doctor should then immediately know which medicine to prescribe. Cures should be effected within one to two weeks or it is thought that the medicine has no value, and that the doctor is "no good."

It must be emphasized that while receiving pills is considered as something positive and that the doctor is competent, it does not imply patient compliance in taking the pills as prescribed. Most herbal preparations are taken on a short-term basis - such as for three days to a week. Often, as soon as a Hmong persons feels better, she/he will discontinue taking the medication. They often feel that taking more is wasteful and that it should be saved for a future illness. On the other hand, if they take a medication for several days and perceive no effect, or worse, experience side effects, they may think that the medication is useless or bad and discontinue taking it. Having to take medication for a year - such as INH therapy, is totally alien and it may be difficult to get compliance for such a therapy among Hmong persons.

RECOMMENDATIONS

1. Use basic straightforward English.
2. Use trained bilingual interpreters when available.
3. Involve the patient's family in any decisionmaking process as much as possible.
4. Encourage or allow the use of any traditional healing arts along with Western treatments, if needed.
5. Whenever possible have Hmong women patients seen by female physicians and Hmong men by male physicians.

6. Whenever possible give a Hmong patient a definite diagnosis as quickly as is feasible.
7. Consider surgery only as a last alternative. Be sure the patient understands that while it may be the doctor's recommendation, it is completely up to the patient to do or not to do it.
8. Extensive counseling and/or health education should be provided to refugees where long-term medication is indicated.
9. Medical staff working with Hmong or other minority patients should be provided with cross-cultural training.

CONCLUSION

The Multnomah County Health Division has been serving refugees since they first began arriving in Oregon twelve years ago. They have an excellent inservice training program which provides all existing and new staff with cross-cultural training. Utilization of the County Health Services among refugees is continuously increasing and well accepted by the local refugee community. Loss of patients due to culturally inappropriate treatment is now very low. As an example, I just completed a study which showed that during 1984-85 only 16.8% of refugees who were started on an INH therapy did not complete their 12 months. This is a considerably much lower rate than found in earlier years.

In conclusion, while barriers towards the Hmong and other refugees accessing and utilizing Western health services still exist, through cross-cultural training for Western health personnel and through health education for the refugees, these barriers can be eliminated.

REFERENCES

1. Bliatout, Bruce T. 1988, "Hmong Attitudes Toward Surgery: How It Affects Prognosis" In: Migration World Magazine. Vol. XV, No. 1, January, 1988.

2. Bliatout, Bruce T. 1986, "Guidelines For Mental Health Professionals To Help Hmong Clients Seek Traditional Health Treatment" In The Hmong In Transition. Edited by Hendricks, Glenn L, et. al. The Center for Migration Studies, 209 Flagg Place, Staten Island, New York, 10304, Pgs. 349-363.

3. Bliatout, Bruce T. et. al. 1985, "Mental Health And Prevention Activities Targeted to Southeast Asian Refugees" In Southeast Asian Mental Health: Treatment, Prevention Services, Training, And Research. National Institute of Mental Health, Center for Prevention Research: Room 11C--06, 5600 Fishers Lane, Rockville, MD, 20052, Pgs. 183-207

4. Chindarsi, N. 1976, The Religion Of The Hmong Njua. The Siam Society, Bangkok, Thailand.

5. Hendricks, G.L., et. al. 1986, The Hmong In Transition. Center for Migration Studies of New York, Inc., 209 Flagg Place, Staten Island, New York, 10304.